STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENTWOOD AT LAPORTE	2002 ANDREW AVE LA PORTE, IN46350

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R0000	This visit was for a State Residential Licensure Survey. Survey dates: April 6 & 7, 2011 Facility number: 010890 Provider number: 010890 AIM number: N/A Survey team: Lara Richards, R.N., T.C. Janet Adams, R.N. Kitty Vargas, R.N. Census bed type: Residential: 118 Total: 118 Census payor type: Other: 118 Total: 118 Sample: 8 These state findings are cited in accordance with 410 IAC 16.2. Quality review 4/11/11 by Suzanne Williams, RN	R0000	This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or the proposed administrative penalty (with right to correct) on the community. Rather it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigation factors.	
R0036	(k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.			
	Based on record review and interview, the facility failed to ensure the residents' physician was notified of blood pressure results and low blood sugars for 2 of 7 records reviewed in the sample of 8. (Residents #1 and #4) Findings include: 1. The record for Resident #1 was reviewed on 4/6/11 at 1:20 p.m. The resident's diagnoses included, but was not limited to, hypertension (high blood pressure). The March 2011 Physician's Order Summary (POS), indicated the resident's blood pressure was to be monitored twice a day and the physician was to be called if the resident's blood pressure was less than 90/60. The November 2010 blood pressure monitoring sheet indicated the resident's blood pressure was 90/40 on 11/12, 96/50 on 11/21, 90/54 on 11/23, and 96/54 on 11/24/10. There was no documentation in the Nursing Progress Notes of the physician being notified of the blood pressure. Interview with the Administrator on	R0036	**Corrective Action:** Resident # 1 and resident's # 4's physicians were notified of the blood pressures or blood sugars on April 16th, 2011. **How to Identify Other Residents:** Any resident with blood pressure or blood sugars parameters have the potential to be affected by this finding. The Resident Care Coordinator and/or designee will audit all the MAR's to check for proper physician notification to ensure compliance by April 30th, 2011. **Systemic Changes:** Brentwood's licensed staff will follow facility policy in regards to physician notification. An in-service will be conducted on April 26th, 2011 with all licensed staff to review the policy and procedures for physician notification. **Monitoring Corrective Actions:** Weekly audits of the MAR's will be conducted by the Resident Care Director to ensure physician notification is being completed per our facility policy.	05/06/2011

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	4/7/11 at 10:00 a.m., indicated there was no documentation to indicate if the physician had been notified of the blood pressure results. 2. The record for Resident #4 was reviewed on 4/6/11 at 12:05 p.m. The resident had diagnoses that included, but were not limited to, diabetes, congestive heart failure and anxiety. Review of the physician's order sheet, dated 2/14/11, indicated the resident was to receive insulin per sliding scale three times per day, based on her blood glucose reading. The physician's order indicated the resident was to receive regular insulin as follows: Blood glucose 0-150 = 0 units of insulin Blood glucose 151-200 = 2 units of insulin Blood glucose 201-250 = 4 units of insulin Blood glucose 251-300 = 6 units of insulin Blood glucose 301-350 = 8 units of insulin Blood glucose 351-400 = 0 units of insulin if greater than 400 give 12 units and call the Doctor		**Corrective Action:** Resident # 1 and resident's # 4's physicians were notified of the blood pressures or blood sugars on April 16th, 2011. **How to Identify Other Residents:** Any resident with blood pressure or blood sugars parameters have the potential to be affected by this finding. The Resident Care Coordinator and/or designee will audit all the MAR's to check for proper physician notification to ensure compliance by April 30th, 2011. **Systemic Changes:** Brentwood's licensed staff will follow facility policy in regards to physician notification. An in-service will be conducted on April 26th, 2011 with all licensed staff to review the policy and procedures for physician notification. **Monitoring Corrective Actions:** Weekly audits of the MAR's will be conducted by the Resident Care Director to ensure physician notification is being completed per our facility policy.	05/06/2011

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	The form titled, "Blood Glucose Tracking," and dated March 2011 was reviewed. On March 12, 2011, before breakfast, the resident's blood glucose was 46, (normal value 65-110). There was no documentation in the record that the physician was notified of the low blood glucose reading. On March 25, 2011, the resident's blood glucose reading was 48 before breakfast. There was no documentation the physician was notified of the low blood glucose reading. The policy titled "Blood Glucose Monitoring" with a revision date of 1/20/11 was provided by the Resident Care Director on 4/6/11 at 1:15 p.m. She indicated the policy was current. The policy indicated, "Licensed staff should report significant changes in blood glucose reading according to parameters to physician." Interview with the Resident Care Director on 4/6/11 at 1:55 p.m. indicated the physician should be notified when a resident's blood glucose reading is below 70. She indicated the resident's physician was not notified of the low blood glucose readings on March 12 and March 25, 2011.			

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	Continued interview with the Resident Care Director on 4/6/11 at 2:25 p.m. indicated Resident #4's physician was contacted on 4/6/11. The physician gave orders that he is to be notified of any blood glucose reading below 70.			
R0120	(e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor.			

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	(D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure the annual three hours of required dementia specific training inservices were provided to 6 of 38 current employees hired before 1/1/10. This deficient practice had the potential to affect 118 residents who resided in the facility. (Employees # 1, #2, #4, #5, #6, and #7) Findings include: The facility employee files and inservice training records were reviewed on 4/7/11 at 10:00 a.m. The following employees had not completed the required three hours of dementia specific training during 1/1/10 through 12/31/10: Employee #1 - CNA hired on 11/23/09 Employee #2- Dietary Wait Staff hired on 6/17/08 Employee #4 - CNA hired on 11/17/07 Employee #5- CNA hired on 12/15/06 Employee #6- CNA hired on 10/4/07 Employee #7- Dietary Wait Staff hired on 8/18/09. When interviewed on 4/7/11 at 1:00 p.m.,	R0120	**Corrective Action:** All employees who have been identified during the survey will complete the 3 hour dementia training by May 6th, 2011. **How to Identify Other Residents:** No residents were affected. All Employees' in service records will be audited by the Business Office Director and/or designee to ensure compliance by April 23rd, 2011. Any Employee not in compliance will have the dementia training completed by May 6th, 2011. **Systemic Changes**: An in service schedule is in place to ensure all staff meet the 3 hour dementia training per year requirement. **Monitoring Corrective Actions:** The Business Office Director and /or designee will track attendance at each scheduled in service to ensure compliance. Any Employee out of compliance will be removed from the schedule until the required in services are completed.	05/06/2011

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	the facility Administrator indicated three hours of dementia specific training should have been completed for all employees who had worked through 2010.			
R0123	(h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to ensure job specific orientation was completed for 3 of 5 employee records reviewed for job specific orientation at the time of hire. This deficient practice had the potential to affect 118 residents residing in the facility. (Employees #8, #9, and #10) Findings include:	R0123	**Corrective Action:** The 3 employee' s identified during the survey have had a job specific orientation completed with them by the Resident Care Director and/or designee by April 30th, 2011. **How to Identify Other Residents:** No residents were affected. All Employees' files will be audited to ensure compliance by April 23rd, 2011 by the Business Office Director	05/06/2011

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	The facility employee records were reviewed on 4/7/11 at 10:00 a.m. There was no documentation of job specific orientation being provided to the following employees: Employee #8- LPN hired on 12/2/10 Employee #9- QMA hired on 2/9/11 Employee #10- CNA hired on 2/9/11 When interviewed on 4/7/11 at 12:25 p.m., the facility Administrator indicated record of job specific orientation for the above employees was not available in the employee records.		and/or designee. **Systemic Changes**: Any employee who does not have a completed job specific orientation will have one completed by May 6th, 2011. **Monitoring Corrective Actions:** The Business Office Director will ensure a completed job description is completed and filed in the Employees' file on every new hire. The Business Office Director and/or designee will audit all new Employee files and will present the findings during the monthly Quality Assurance meetings to ensure 100% compliance ongoing.	
R0144	(a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to provide a clean environment related to marred walls and doors in the Memory Care Unit. This had the potential to affect 33 of 33 residents residing in the Memory Care Unit. Findings include: 1. During the environmental tour, on 4/7/11 at 9:30 a.m., with the Maintenance	R0144	**Corrective Action:** The walls and doors in the Memory Care Neighborhood that needed to be touched up will be painted by April 23rd, 2011. **How to Identify Other Residents:** No residents were affected. **Systemic Changes**: All staff will be in serviced on how to inform the Environmental Supervisor what in the community needs attention, such as marred walls and doors by April	05/06/2011

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	Director, the following was observed: a. 3 of 4 walls in the dining room in the Memory Care Unit had black marks and mars. The walls were marred on the lower three feet of the walls. b. The bathroom door in room 402 had black areas on the bottom 12 inches. c. The community bathroom door had black areas on the bottom 12 inches. d. The door to room 405 had black areas on the bottom 12 inches. e. The door to room 410 had black areas on the bottom 12 inches. Interview with the Maintenance Director at the time of the environmental tour, indicated all the above areas in the Memory Care Unit were marred and in need of paint. He indicated the marred walls and doors were due to walkers and wheelchairs hitting them.		28th, 2011. **Monitoring Corrective Actions:** The Environmental Supervisor will be responsible for sustained compliance by completing environmental rounds of the community and reporting findings to the Quality Assurance Committee monthly. Page one of the Environmental section of the Comprehensive Process Review will be used to conduct the rounds of the community.	
R0217	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the:			

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	(A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on record review and interview, the facility failed to ensure service plans were signed and dated by the resident, for 1 of 7 records reviewed, in a sample of 8. (Resident #4) Findings include: The record for Resident #4 was reviewed on 4/6/11 at 12:05 p.m. The resident was admitted to the facility on 2/14/11 and had diagnoses that included, but were not limited to, diabetes, congestive heart failure and anxiety.	R0217	**Corrective Action:** Resident #4's service plan has been reviewed and signed with the resident on 4/6/2011. **How to Identify Other Residents:** All residents who reside in Brentwood's Assisted Living or Memory Care Neighborhood have the potential to be affected by this finding. The Resident Care Director and/or designee will complete an audit of all the residents who currently reside in the assisted living and memory care neighborhood to ensure that they are signed by the resident and/or family by April 30th, 2011.	05/06/2011

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	The service plan for the resident was completed by the Resident Care Director on 3/16/11. The Resident Care Director had signed the service plan and dated the form 3/16/11. Review of the service plan indicated the resident had not signed and dated the form. Interview with the Resident Care Director on 4/6/11 at 1:30 p.m., indicated the resident was alert and oriented and was capable of signing the service plan. She also indicated the resident's signature was not on the service plan. Interview with the resident on 4/6/11 at 2:15 p.m., indicated the resident did not recall participating in her service plan.		**Systemic Changes**: The Resident Care Coordinator will be responsible to ensure all service plans are signed by the resident and/or family after completion of any assessment. **Monitoring Corrective Action:** Random audits of the resident records will be completed by the Resident Care Director and/or designee monthly and the findings will be reported to the Quality Assurance Committee to ensure compliance.	
R0306	(g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the			

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	disposal of the drug. Based on record review and interview, the facility failed to ensure a medication disposition form had been completed for 1 of 2 closed records reviewed in the sample of 8. (Resident #6) Findings include: The record for Resident #6 was reviewed on 4/6/11 at 10:30 a.m. Review of the March 2011 Physician's Order Summary (POS), indicated the resident received Lasix (a water pill) 20 milligrams (mg) daily and Nitroglycerine ER (a heart medication) 2.5 mg twice a day. The resident expired at the facility on 3/8/11. A medication disposition form was not available for review. Interview with the Administrator on 4/7/11 at 10:00 a.m., indicated a medication disposition form had not been completed.	R0306	**Corrective Action:** Resident # 6 was discharged in February from Brentwood. **How to Identify Other Residents:** Any resident who has their medications administrated by the licensed staff at Brentwood and has been discharged has the potential to be affected by this finding. **Systemic Changes:** The Resident Care Director and/or designee will be responsible to ensure that any resident who has their medication administered by the licensed staff and is discharged, has a record of medication disposition form completed at the time of discharge. **Monitoring Corrective Actions:** Chart audits of residents who have been discharged from the community will be completed by the Resident Care Director and/or designee. The findings will be reported in the monthly Quality Assurance Committee to ensure compliance.	05/06/2011